VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

September 15, 2015

Ms. Jennifer Bibeault, Manager
Brookwood
2 School Street
North Springfield, VT 05150

Dear Ms. Bibeault:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 18, 2015.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0115	A. BUILDING: _____ B. WING _____	C 06/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKWOOD	2 SCHOOL STREET NORTH SPRINGFIELD, VT 05150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site investigation of 3 Residential Care Home (RCH) self reports was conducted on 6/16/15 and completed on 6/18/15. The following regulatory violations were identified.	R100		
R151 SS=B	V. RESIDENT CARE AND HOME SERVICES 5.9.c (8) Ensure that the resident's record documents any changes in a resident's condition; This REQUIREMENT is not met as evidenced by: Based on record review, the owner/manager failed to document in 1 of 2 applicable resident records information regarding an incident involving a resident and an employee of the RCH. (Resident # 1) Findings include: During the week of 4/26/15, Resident #1 was subjected to verbal abuse by Caregiver #1 during the overnight hours when the resident was being provided assistance with toileting. Resident #1 had informed Caregiver #2 at the RCH about the incident and stated s/he was afraid of Caregiver #1. When interviewed by the RCH owner/manager, Resident #1 confirmed that during one of the overnights during the week of 4/26/15 when Caregiver #1 was working, the resident was subjected to swearing and yelling by Caregiver #1 when the resident had become incontinent. Caregiver #1 informed the resident that s/he was capable of going to the bathroom on his/her own. Upon requiring assistance with a protective underwear brief, Caregiver #1 again became abusive, throwing the brief at Resident	R151	A form will be developed for any incident that is out of the ordinary such as falls, inappropriate interactions, verbal abuse, ect.. This will be completed separately by any employee involved or having knowledge of incident. Will be completed before leaving facility the day of occurence. and reported to RN will get all written forms - speak with resident and all involved and document in record of resident all gathered information and emotional effect and any physical effect on resident. Policy to be in effect	

R151 - R272 POCs accepted 9/14/15 FMcIntosh RN/PME

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R151	Continued From page 1 #1. Although the incident was acknowledged, there was no written document in Resident #1's record regarding the significant events and how the resident was feeling emotionally. This was confirmed with the owner/manager via telephone interview on 6/18/15 at 11:35 AM.	R151	Staff trained on use of form, how to complete and Chain of command for reporting by 7/17/15.	7/17/15
R173 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h. (1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel shall have access to the keys This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the RCH failed to assure resident medications were stored and locked and not accessible to unauthorized individuals. Findings include: Per observation on the afternoon of 6/16/15, medications belonging to Residents #3 and #4 were stored on top of a cabinet in the owner/manager's office. Staff present at the time of observation stated some of the medications were brought from home by Resident # 4 and the medications for Resident #3 should have been stored in the medication closet. The office is accessible to all staff and one of the two exits to this office is connected directly to a resident's	R173	All medications will be stored in med closet with lock inside of home. Any medications brought by family that can't be used will be sent home with family OR properly disposed of by facility. The door to office from Residents room is Locked 24°/day Now with access only from Within office. No access from Residents Room.	6-30-15 6-30-15

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R173	Continued From page 2 room. The office remained unlocked. This was confirmed by telephone interview on 6/18/15 at 11:43 AM with the owner/manager on the RCH.	R173	Medication that has been discontinued will be disposed of or returned to pharmacy. Any medication that is temporarily in office to be returned to pharmacy will be kept in locked office safe until returned. Effective 7-15-15	
R206 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be contacted by calling toll-free 1-800-564-1612. Reports must be made to APS within 48 hours of learning of the suspected, reported or alleged incident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, RCH staff, as mandated reporters, failed to report to Adult Protective Services (APS) within 48 hours of learning of suspected abuse for 1 applicable resident. (Resident #1) Findings include: On the morning of 4/30/15 there was a discussion between 2 employees at the RCH regarding an allegation of abuse made by a resident. Resident #1 had informed Caregiver #2 that during the week of 4/26/14 s/he was subjected to verbal abuse by Caregiver #1 who worked on the overnight shift. The information was provided to the owner/manager on 5/1/15. Subsequently a second complaint was then voiced by another resident on 5/2/15 about Caregiver #1 to the owner/manager regarding an additional incident of abuse by Caregiver #1. When staff was first made aware of the incident involving Resident #1	R206	To ensure all reports of 7-17-15 suspected abuse, neglect or exploitation be made within 48 hours of events following will be put into place 1- continued education with staff on their role in abuse reporting – (mandated Reporter) 2- incident repeat to be filled out before end of shift and verbal repeat to on call administrator. This will eliminate staff from reporting to each other instead will go directly to administrator. This should decrease time delay.	

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R206	Continued From page 3 there was a failure to report the initial event to APS within the required 48 hours. It was not until 5/5/15 that a report was called into APS of the both incidents of suspected abuse. This was confirmed per telephone interview on 6/18/15 at 11:40 AM with the RCH owner/manager that staff failed to promptly report the allegations of abuse.	R206	3- continued education on importance of reporting all issues. 4. RN/ administrator will report suspected abuse Neglect exploitation within 48 hours if has NOT been reported by staff.	
R213 SS=G	VI. RESIDENTS' RIGHTS 6.1 Every resident shall be treated with consideration, respect and full recognition of the resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview and record review 2 elderly residents residing in the RCH were not treated with consideration and dignity during the provision of care by RCH staff. (Residents #1 & #2) Findings include: 1. During the week of 4/26/15 Resident #1 was subjected to verbal abuse by Caregiver #1 during the overnight hours when the resident was being provided assistance with toileting. Resident #1 had informed Caregiver #2 at the RCH about the incident and stated s/he was afraid of Caregiver #1. When interviewed by the RCH owner/manager, Resident #1 confirmed that during one of the overnights during the week of 4/26/15 when Caregiver #1 was working, the resident was subjected to swearing and yelling by Caregiver #1 when the resident had become incontinent. Caregiver #1 informed the resident that s/he was capable of going to the bathroom	R213	This Plan is for both violation 6.1 + 6.12. 9-1-15 These instances were reviewed with all Staff in an additional meeting about abuse, Neglect + exploitation, + Reporting requirements. extensive training + discussion around verbal abuse. Currently Brookwood is developing an abuse Prevention program. to be given yearly to staff and during orientation to new employees. – in addition to yearly abuse Neglect, exploitation inservice This program will focus on competencies for all caregivers	

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R213	Continued From page 4 on his/her own. Upon requiring assistance with a protective underwear brief, Caregiver #1 again became abusive, throwing the brief at Resident #1. In addition, during the overnight hours, Resident #1 was often not being assisted to use the bathroom by Caregiver #1 resulting in Resident #1 becoming incontinent which would then trigger verbal berating by Caregiver #1. Per interview on the afternoon of 6/16/15, Resident #1 reconfirmed the incident and expressed how badly s/he had felt about the incident and humiliated by Caregiver #1. Per review of the Resident Mobility Assessment dated 5/6/15 noted Resident #1 required extensive assistance with toileting and transfers. The resident's care plan also noted Resident #2 required assistance when using the bathroom and changing undergarments. 2. On the morning of 5/2/15 the covering nurse for the RCH was asked to speak with Resident #2 regarding an incident which had occurred during the overnight hours. Resident #2 reported to the nurse "S/he had a really rough night" stating that at approximately 5:00 AM on 5/2/15 while being assisted out of bed by Caregiver #1 his/her knee gave out and s/he fell to the floor. While on the floor, Caregiver #1 stood over the Resident #1 and yelled to her/him to "get the F.... up" multiple times. The resident reported s/he started to cry and eventually Caregiver #1 got the resident to the recliner in his/her room. Per interview on 6/16/15 at 11:30 AM the covering nurse stated Resident #2 reported how upset s/he was about the incident. Resident #2 also stated s/he was nervous about Caregiver #1 returning to work and continuing to provide care to Resident #2. The nurse also noted staff failed to notify her regarding Resident #2's fall, as required per RCH policy. Per interview on 6/16/15 at 10:45 AM	R213	This will include education on abuse, neglect + exploitation, but also subtle forms of abuse such as dignity issues, Psychological coecion, Rough handling, retaliatory abuse + petty theft. This will include + Verbal + non verbal communicata Strategies with residents ie- tone body language + Strategies for communicata among staff around residents Needs. + Identify stressors in caregivers lives that could potentially increase incidents of abuse. + identify behaviors diagnoses that could put resident at higher risk for abuse. + Educate on core values related to caregiving. - Care for human kind compassion empathy protect those who can not protect themselves. + Teamwork - supporting coworkers helping out each other appreciate what everyone does - How teamwork can ↓ stress. - How positive work environment can ↓ stress. cooperative efforts promote quality care	

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R213	Continued From page 5 Resident # 2 reconfirmed the incident and recalls Caregiver #1 as "abrasive". Per review of Resident Assessment dated 2/3/15 for Mobility, Resident #2 required extensive assistance for toileting and transfers. Per telephone interview on 6/16/15 at 11:55 AM, the owner/ manager confirmed the reported incidents involving Caregiver #1 and the 2 residents. The owner/manager also confirmed Caregiver #1's employment was terminated on 5/3/15, had not returned to work after 5/2/15 and a report was filed with Adult Protective Services.	R213	Reporting abuse - Educate that it is Not talking on a co worker - mandatory reporters. Not our job to decide if it is abuse our job to report. Residents care - Educate - We are customer service providers - We are guests in their home - How diagnosis can effect behaviors. ie diabetics dementia. - Know difference between appropriate + inappropriate responses to resident behaviors that are viewed as problematic. Will educate in appriate and inappropriate responses. Will Teach Strategies to reduce conflict ie empathy active listening. - in addition to the above education 2 x a year a	
R224 SS=G	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interview, the RCH failed to assure all residents were free from both verbal and physical abuse for 2 applicable residents. (Residents #1 & 2) Findings include: 1. During the week of 4/26/15 Resident #1 was subjected to verbal abuse by Caregiver #1 during the overnight hours when the resident was being provided assistance with toileting. Resident #1 had informed Caregiver #2 at the RCH about the incident and stated s/he was afraid of Caregiver #1. When interviewed by the RCH owner/manager, Resident #1 confirmed that	R224		

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R224	Continued From page 6 during one of the overnights during the week of 4/26/15 when Caregiver #1 was working, the resident was subjected to swearing and yelling by Caregiver #1 when the resident had become incontinent. Caregiver #1 informed the resident that s/he was capable of going to the bathroom on his/her own. Upon requiring assistance with a protective underwear brief, Caregiver #1 again became abusive, throwing the brief at Resident #1. In addition, during the overnight hours, Resident #1 was often not being assisted to use the bathroom by Caregiver #1 resulting in Resident #1 becoming incontinent which would then trigger verbal berating by Caregiver #1. Per interview on the afternoon of 6/16/15, Resident #1 reconfirmed the incident and expressed how badly s/he had felt about the incident and humiliated by Caregiver #1. Per review of the Resident Mobility Assessment dated 5/6/15 noted Resident #1 required extensive assistance with toileting and transfers. The resident's care plan also noted Resident #2 required assistance when using the bathroom and changing undergarments. 2. On the morning of 5/2/15 the covering nurse for the RCH was asked to speak with Resident #2 regarding an incident which had occurred during the overnight hours. Resident #2 reported to the nurse "S/he had a really rough night" stating that at approximately 5:00 AM on 5/2/15 while being assisted out of bed by Caregiver #1 his/her knee gave out and s/he fell to the floor. While on the floor, Caregiver #1 stood over the Resident #1 and yelled to her/him to "get the F.... up" multiple times. The resident reported s/he started to cry and eventually Caregiver #1 got the resident to the recliner in his/her room. Per interview on 6/16/15 at 11:30 AM the covering nurse stated Resident #2 reported how upset s/he was about	R224	Psychologist will attend Staff meeting for staff to discuss problems and frustrations they are encountering offer guidance + support.	

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R224	Continued From page 7 the incident. Resident #2 also stated s/he was nervous about Caregiver #1 returning to work and continuing to provide care to Resident #2. The nurse also noted staff failed to notify her regarding Resident #2's fall, as required per RCH policy. Per interview on 6/16/15 at 10:45 AM Resident # 2 reconfirmed the incident and recalls Caregiver #1 as "abrasive". Per review of Resident Assessment dated 2/3/15 for Mobility, Resident #2 required extensive assistance for toileting and transfers. Per telephone interview on 6/16/15 at 11:55 AM, the owner/ manager confirmed the reported incidents involving Caregiver #1 and the 2 residents. The owner/manager also confirmed Caregiver #1's employment was terminated on 5/3/15, had not returned to work after 5/2/15 and a report was filed with Adult Protective Services.	R224		
R266 SS=E	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the RCH failed to maintain a safe and sanitary environment. Findings include: During the course of the onsite visit to the RCH the following observations were made: 1. A dusty and soiled fan was in use in the kitchen throughout the day while food was be	R266	- All equiptment - especially 6-20-15 Seasonal equiptment will be on scheduled cleaning rotation - if taken out of Storage will be cleaned before using. - Will develop checklist - 7-15-15 for Maintenence to - Check all equiptment monthly. and clean - Clean all equiptment	

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R266	Continued From page 8 prepared. 2. In upstairs bedroom next to the bathroom, 2 of the windows had large cracked panes of glass on the storm windows. The potential for harm could occur if the windows were opened. 3. At the backdoor, which accessed to yard and deck area, a large opened bag of bird seed was observed. Beside the bag of seed and close to the floor was a previously used vent pipe which exited to the outside and was partially covered with duct tape, providing easy access by pests to enter the RCH drawn by opened bird seed bag and other food sources within the property. 4. In the kitchen a 12 x 12 tile near the entrance to the dinning room was damaged with protruding edges and un-level surface creating a fall hazard for both residents and staff. During the onsite, residents were observed ambulating through the kitchen into the dinning room. Per telephone interview on 6/18/15 the owner/manager confirmed findings observed by the surveyor.	R266	Removed from storage - Maintenence to put all bird seed Rock Salt in covered containers - 6-23-15 - Checklist will be made for Maintenence to reach Room monthly for hazards. open ducts, broken windows cords ect.... will keep for documentation. - will put plastic over broken window. All upstairs windows to be replaced 9-15-15 in August or Sept based on scheduling. - plastic will Prevent any potential injury	
R272 SS=D	IX. PHYSICAL PLANT 9.2 Residents' Rooms 9.2.e Resident bedrooms shall be used only as the personal sleeping and living quarters of the residents assigned to them. This REQUIREMENT is not met as evidenced by: Based on observations during the onsite complaint investigation, staff repeatedly passed through a room where 2 residents resided in order to enter the RCH office. (Resident #5 & #6) Findings include:	R272	Door from Residents Room is locked going into office from office Side. Employees or Residents can Not enter office through residents Room. 6-18-15	

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R272	Continued From page 9 Resident # 5 and Resident #6 share a room in the annex side of the RCH. During the onsite, staff directed the surveyor several times through the room belonging to the residents in order to access the RCH office. Although there was another entrance to the office by an outside exit door, staff did not utilize this option and repeatedly walked through Resident #5 & 6's room. At times a resident was sitting in their room when staff accessed the office. Per telephone interview on 6/18/15 at 11:45 AM, the owner/manager confirmed staff do access the office by directly passing through a resident's room.	R272		